Kentucky Department for Medicaid Services

Pharmacy and Therapeutics Advisory Committee Recommendations

March 20, 2008 Meeting

The following chart provides a summary of the recommendations that were made by the Pharmacy and Therapeutics Advisory Committee at the March 20, 2008 meeting. Review of the recommendations by the Secretary of the Cabinet for Health and Family Services and final decisions are pending.

	Description of Recommendation	P & T Vote
#1	**Low Molecular Weight Heparins (Previously tabled)** **1.** Agents not selected as preferred will require a prior authorization **2.** Require therapeutic failure of one preferred agent prior to approval of non-preferred agents **3.** Allow continuation of therapy for agents selected as non-preferred for patients who have a history within the last 30 days **4.** For any new chemical entity, product, or dosage form of Low Molecular Weight Heparins, require a prior authorization until reviewed by the P & T Advisory Committee **5.** Arixtra can not be sole preferred agent	**Passed** - 8 for - 0 against
#2	**Anticonvulsants (Previously tabled) First Generation** **1.** DMS to select all single source brand agents **2.** Agents not selected as preferred will require prior authorization, but will remain at a Tier 1 co-payment for generic alternatives, and a Tier 2 co-payment for branded products **3.** Require therapeutic failure of preferred agent prior to approval of a non-preferred agent **4.** Allow continuation of therapy for agents selected as non-preferred for patients who have a history within the last 90 days	**Passed** - 8 for - 0 against
#3	**Anticonvulsants (Previously tabled) Second Generation** **1.** DMS to select all single source brand agents **2.** Agents not selected as preferred will require prior authorization, but will remain at a Tier	**Passed** - 8 for - 0 against

	1 co-payment for generic alternatives, and a Tier 2 co-payment for branded products **3.** Require therapeutic failure of preferred agent prior to approval of a non-preferred agent **4.** Allow continuation of therapy for agents selected as non-preferred for patients who have a history within the last 90 days	
#4	**Anticonvulsants (Previously tabled)** **Carbamazepine Deriviatives** **1.** DMS to select all single source brand agents **2.** Agents not selected as preferred will require prior authorization, but will remain at a Tier 1 co-payment for generic alternatives, and a Tier 2 co-payment for branded products **3.** Require therapeutic failure of preferred agent prior to approval of a non-preferred agent **4.** Allow continuation of therapy for agents selected as non-preferred for patients who have a history within the last 90 days	**Passed** - 7 for - 1 against
#5	**Antimigraine Agents, Triptans** **1.** Agents not selected as preferred based on economic evaluation will require PA **2.** Continue to require failure of a preferred agent(s) before PA approval of a non-preferred agent **3.** Continue monthly quantity limits per manufacturer's guidelines, with PA required for additional medication **4.** As part of quantity limit override criteria, require the patient to be on concurrent migraine prophylaxis medication (beta blocker, tricyclic antidepressant, calcium channel blocker, etc.) at a therapeutic dose **5.** Require PA for duplicate therapy/concurrent use of triptans by different routes **6.** For any new chemical entity in the triptan class, require a PA until reviewed by the P&T Advisory Committee	**Passed** - 8 for - 0 against
#6	**Antiemetics, Oral** **1.** Continue quantity limits (No PA) –Request for higher doses would require PA	**Passed** - 8 for - 0 against

	2. For any new chemical entity in the Antiemetics 5-HT3 class, require a PA and quantity limit until reviewed by the P&T Advisory Committee **3.** For any new chemical entity in the antiemetics cannabinoid class, require a PA and quantity limit until reviewed by the P&T Advisory Committee **4.** A Prior Authorization (PA) is required if the quantity requested is more than what is recommended in the packaging insert (The quantity limit must coincide with the packaging insert, the brand and generic quaintly limits will be the same)	
#7	**Antivirals, Topical** **1.** Agents not selected as preferred based on economic evaluation will require PA **2.** For any new chemical entity in the topical antivirals class, a PA will be required until reviewed by the P&T Advisory Committee **3.** Abreva OTC can not be sole preferred agent	**Passed** - 8 for - 0 against
#8	**Anti-infectives - Hepatitis B Agents, Oral** **1.** All products in the Hepatitis B oral anti-infectives class are considered clinically equivalent in efficacy and safety in adults **2.** DMS to select agent(s) as preferred based on economic evaluation. **3.** Clinical safety and efficacy for adefovir, telbivudine and entecavir has not been established for pediatric use. Appropriate age edits should be entered into the system, requiring clinical PA for these products when prescribed for children. **4.** For any new chemical entity in the anti-infectives: Hepatitis B, oral class, requires a PA until reviewed by the P& T Advisory Committee**.**	**Tabled**
#9	**Immunomodulators, Injectable: Clinical Edit TNF Antagonists** **1.** Add new FDA indications of Crohn's disease and JIA to existing criteria for Humira. **2.** Criteria to receive a PA for Humira- the recipient must fail 2 (two) of the current conventional therapy's traditionally used to	**Passed** - 8 for - 0 against

	treat patients with severe Crohn's disease **3.** Modify existing quantity limits for Humira for Crohn’s disease to a Quantity limit of 7 (seven) for the first month and then 4 per month afterwards. **4.** All other components of program remain in place	